**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

UNIVERSITY OF TENNESSEE MEDICAL CENTER
PO BOX 440164
NASHVILLE TN 37244

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

**Respondent Name**
AMERICAN & FOREIGN INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 11

**MFDR Tracking Number**
M4-10-4236-01

**MFDR Date Received**
MAY 27, 2010

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary as stated on the Table of Disputed Services:** "Patient admitted from ER – ambulance transport – we tried to obtain auth & they would not issue auth for the stay."

**Amount in Dispute:** $29,849.02

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Please see attached DWC-62 that was sent to the provider on Marcy 18, 2010. The services were not rendered by an authorized physician and the provider did not obtain prior authorization. The provider has not properly submitted a request for reconsideration of the original denial."

**Response Submitted by:** Arrowpoint Capital, PO Box 1000, Charlotte, NC 28201

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 31, 2010 through February 2, 2010 | Inpatient Hospital Services | $29,849.02 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code Section §133.250 sets out the procedures for reconsideration for payment of medical bills
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 18, 2010
   - 40 – No Emergency/Urgent care

**Issues**

1. Is the requestor an out of state provider rendering services to an injured employee with an existing Texas Workers' Compensation claim?
2. Did the requestor submit a request for reconsideration to the respondent in accordance with 28 Texas Administrative Code §133.250?

**Findings**

1. The requestor provided surgical services in the state of Tennessee January 31, 2010 through February 2, 2010 to an injured employee with an existing Texas Workers' Compensation claim. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. In accordance with 28 Texas Administrative Code §133.307(c)(2)(A) a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills) and (B) a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. Review of the submitted documentation does not support that a request for reconsideration was made by the requestor. As a result the amount ordered is $0.00

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | March 22, 2013<br>Date |
|---|---|---|

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.